2009 H1N1 Influenza Vaccine Consent Form (POV)

PANHANDLE HEALTH DISTRICT
8500 N. Atlas Road, Hayden, ID 83835 208-415-5180

Section 1: Information Required to Receive Vaccine (please print)

PATIENT'S NAME (Last)	(First)	(M.I.)	**PATIENT'S DATE OF BIRTH** month_____ day_____ year _____	
PARENT/LEGAL GUARDIAN'S NAME (Last)	(First)	(M.I.)	**PATIENT'S AGE**	**GENDER** M / F
ADDRESS			**PATIENT/PARENT DAYTIME PHONE NUMBER:**	
CITY	**STATE**	**ZIP**		
POV/CLINIC LOCATION:				

Section 2: Screening for Vaccine Eligibility (Children age 9 and under require two doses of vaccine.)

If the patient has already been vaccinated with 2009 H1N1 influenza vaccine, please tell us the number of doses and dates of vaccination.

☐ Dose 1 Date received: month ____day____year_____ Type (please circle): nasal spray shot

☐ Dose 2 Date received: month ____day____year_____ Type (please circle): nasal spray shot

The following questions will help us to know if the patient can get the 2009 H1N1 influenza vaccine. Please mark YES or NO for each question.

A. If you answer "NO" to all four of the following questions, the patient can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, the patient may still be able to get the 2009 H1N1 vaccine, but please contact your doctor to discuss your options.

	YES	NO
1. Does the patient have a severe allergy to eggs?	☐	☐
2. Is the patient allergic to any of the following: gelatin, Gentamicin, Polymyxin, Neomycin?	☐	☐
3. Has the patient ever had a serious reaction to a previous dose of flu vaccine?	☐	☐
4. Has the patient ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐

B. There are two kinds of 2009 H1N1 influenza vaccine. Your answers to the following questions will help us know which of the two kinds of vaccine the patient can get.

	YES	NO
1. Has the patient been vaccinated with any vaccine (not just flu) within the past 30 days? Vaccine: _____ Date given: month_____day_____year_____	☐	☐
2. Does the patient have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves, or blood?	☐	☐
3. Is the patient on long-term aspirin or aspirin-containing therapy (for example, does the patient take aspirin every day)?	☐	☐
4. Does the patient have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer)?	☐	☐
5. Is the patient pregnant?	☐	☐
6. Does the patient have close contact with a person who needs care in a protected environment (for example, someone who has recently had a bone marrow transplant)?	☐	☐

Section 3: Consent

CONSENT FOR VACCINATION:

I have read or had explained to me the 2009-2010 Vaccine Information Statement for the 2009 H1N1 influenza vaccine and understand the risks and benefits.

I GIVE CONSENT to Panhandle Health District and its staff for me/the patient named at the top of this form to be vaccinated with this vaccine.

Signature of Patient/Parent/Legal Guardian _____ Date: month_____day_____year_____

Relationship to child: _____

Section 4: Permission to Release Information

I give permission to **enroll** the patient and to **transfer** the patient's immunization records into the **Idaho Immunization Reminder Information System (IRIS)** to ensure that this vaccination record is available to the patient, the patient's healthcare providers, childcare providers, and schools. I understand I may be asked for information that will help ensure the patient's records are accurate and will not be confused with another person's records, such as: mother's maiden name, gender, and child's eligibility for free vaccine. I authorize inclusion of all information into IRIS and redisclosure of this information from IRIS to authorized users. (The patient can still receive the vaccination if you do not authorize the release below.)

Date: month_____day_____year_____ _____ Signature of Patient/Legal Guardian / (Relationship to child)

Section 5: Vaccination Record

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Dose Administered	Route	Dose Number (1st or 2nd)	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
2009 H1N1	/ /	☐ IM ☐ Intranasal		Sanofi GSK Novartis MedImmune CSL		
2009 H1N1	/ /	☐ IM ☐ Intranasal		Sanofi GSK Novartis MedImmune CSL		